

Hunter, D., McCallum, J. and Howes, D. (2018) Compassion in emergency departments. Part 2: barriers to the provision of compassionate care. *Emergency Nurse*, 26(3), pp. 28-33. (doi:[10.7748/en.2018.e1775](https://doi.org/10.7748/en.2018.e1775))

This is the author's final accepted version.

There may be differences between this version and the published version. You are advised to consult the publisher's version if you wish to cite from it.

<http://eprints.gla.ac.uk/166522/>

Deposited on: 18 February 2019

Emergency Nurse

XXXX

XXXX

Compassion in emergency departments. Part 2: barriers to the provision of compassionate care

Hunter D et al (2017) Compassion in emergency departments. Part 2: barriers to the provision of compassionate care.

Emergency Nurse.

Date of submission: 30 August 2017; date of acceptance: 30 October 2017. doi: 10.7748/en.2017.e1775

David J. Hunter

Lecturer in adult health, University of the West of Scotland, Paisley Campus, Renfrewshire, Scotland

Jacqueline McCallum

Assistant head of department, Glasgow Caledonian University, Glasgow, Scotland

Dora Howes

Associate professor, School of Medicine Dentistry and Nursing, University of Glasgow, Glasgow, Scotland

Correspondence

david.hunter@uws.ac.uk

Conflict of interest

None declared

Peer review

This article has been subject to external double-blind review and has been checked for plagiarism using automated software

Online

For related information, visit emergencynurse.co.uk and search using the keywords

Write for us

For information about writing for RCNi journals, contact writeforus@rcni.com

For author guidelines, go to rcni.com/writeforus

Abstract

In the second part of this three-part series, David Hunter and colleagues discuss barriers to the provision of compassionate care in emergency departments (EDs). Part one reported the doctoral level research that explored the experiences of nursing students in EDs in relation to compassionate care. Many of the findings related to what the nursing students considered as barriers to the provision of compassionate care in this clinical environment. Six barriers to compassionate care were identified, and this article considers them in detail.

compassionate care, emergency department, emergency nurse, exploratory-descriptive qualitative research, student experience

Introduction

This article discusses some of the findings of a qualitative study that explored the experiences of 15 nursing students in emergency departments (EDs) in relation to compassionate care [note to sub. Add reference to previous article here and ref list], namely barriers to the provision of compassionate care in this clinical setting. The student participants did not have difficulty identifying what they considered barriers, which highlights the realities of emergency nursing. Six barriers were identified and are discussed below, along with direct quotations to illustrate the students' thoughts. The six barriers are:

- Alcohol- and drug-related presentations.
- Mental health issues and aggression.
- Regular attendees.
- Physicality of the department.
- Time and government targets.
- Staffing levels.

Alcohol- and drug-related presentations

The findings highlight a recurring discussion with nursing students about patients who present with alcohol- or drug-related issues [do you mean that this topic is often discussed by students in general, or the participants during their interviews?]. This is unsurprising as 35% of all UK ED presentations may be alcohol related, increasing to 70% at peak times during weekends (Currie et al 2015). Presentations associated with recreational drug use were also explored by the participants. Archer et al (2013) found that of those who attended an ED, 46% had used one or more recreational drugs with alcohol, 31% had drunk alcohol alone, and 23% had used recreational drugs alone.

During the discussion of this patient group, participants reported that compassionate care was lacking, and suggested that staff perceive these patients as a nuisance, or are dismissive about their reasons for attending EDs. The participants also highlighted that intoxicated patients were less likely to be offered oral fluids or blankets for comfort and warmth. While they recognised the complexity of alcohol and drug misuse, the participants reported that ED nurses were frustrated at having to care for such patients over others, or that their attitudes towards these patients was less compassionate than to others. One participant said: 'You were getting people who were coming in just maybe drunk off the street... some of the staff seen them as a nuisance or just wanting them treated and gone' (Thomas).

The participants' experiences are mirrored in the literature. For example, Warren et al (2012) found that while emergency nurses and doctors agreed that intoxicated patients should be treated with respect, the reality was different, leading to a breakdown of compassionate care, while Indig et al (2009) identified that 85% of ED staff who took part in their study believed that patient's state of intoxication created a barrier to treatment. Conversely, a study of nurses from four wards in a large teaching hospital found that they held positive or at least neutral attitudes towards patients with alcohol problems (Crothers and Dorrian 2011).

One explanation for this could be that ED nurses deal with patients who present with acute intoxication and its associated issues, such as verbal and physical abuse, while patients admitted to hospital wards will have either been injured while drunk or be living with an alcohol-related condition such as liver cirrhosis. Ferns and Cork (2008a) highlighted the relationship between alcohol intoxication and aggression, and suggested that patients' thought processes, responses and behaviours vary as a result of the physical and psychological effects of consuming alcohol.

They concluded by recognising the complexities associated with how best to manage alcohol-related aggression in EDs (Ferns and Cork 2008b).

The participants in this study identified alcohol- and drug-related presentations as barriers to compassionate care, but also provided positive examples: 'A lot of it comes down to substance misuse or alcohol misuse, but there was one particular patient who had come in, on the flipside, who got really good compassionate care. She was in her 40s, she had a drink problem, em, she was referred to substance misuse nurses. They were so patient with her. She was really upset with herself. She was losing her family as a result of it and they did take the time, one of the doctors in particular was fantastic. He was really, really good' (Lucy). Although alcohol was the contributing factor to the woman's admission, she was not disruptive which could explain why she received compassionate care. Her age and gender could also be factors, as Rolfe et al (2006) suggested that aggressive behaviours were more likely in people they defined as 'drinking heavily' if patients were young males.

Mental health issues and aggression

The participants perceived similarities between the way patients with mental health issues or who displayed aggression were treated and those with alcohol or drug presentations. Delaforce and Dolan (2013) defined a psychiatric emergency as 'any disturbance in the client's thoughts, feelings or actions for which immediate therapeutic intervention is necessary', and highlighted that emergency nurses' who manage various life-threatening situations regularly might not recognise a mental health crisis as a true emergency. The number of people who present to EDs with self-harm or attempted suicide is significant, although exact figures are not recorded (Polling et al 2015), however estimates suggest there are approximately 170,000 presentations in UK EDs each year (Jones and Avies-Jones 2007).

Participants highlighted that one barrier to compassionate care of patients with mental health issues, particularly self-harm or suicidal ideation, was their refusal of help. They discussed nurses having a 'why bother' response after attempts to offer care were refused. Conlon and O'Tuathail (2012) noted that the focus of care in EDs is on physical injuries, and that self-harming patients are considered manipulative, attention seeking or beyond help. However, McCann et al (2006) found that emergency nurses had supportive attitudes towards patients who had self-harmed. A quote by one of the student participants illustrates this: 'Some of the patients that were coming in, they were suicidal, some of them abusive, aggressive and it was quite difficult at times to try and provide that sort of care (compassionate care) for them when they didn't themselves really want to be receiving (it)...' (Lucie).

Another significant barrier to compassionate care is aggression (Tan et al 2015). Participants made clear links between alcohol- and drug-related presentations and some mental health patients with aggressive behaviours: 'Patients coming in with alcohol excess, with falls and injuries, but were still quite intoxicated and were quite aggressive at times, that was quite tough' (Lucie).

Gilchrist et al (2011) suggested that alcohol is regularly identified by ED staff as the primary cause of aggressive or violent incidents. The participants recognised that violence and aggression could occur without these factors, for example when relatives receive bad news, however the overwhelming cause cited by the students was related to alcohol, drugs and/or mental health issues. Research suggests that violence and aggression in EDs is under-reported (McLaughlin et al 2009, Neades 2013). This is partly because nurses may perceive it as part of the job (McLaughlin et al 2009, Tan et al 2015), but they may also be reluctant to report incidents out of a sense of duty to patients, and as a way of appearing compassionate (Powley 2013).

The student participants recognised their limitations when it came to providing care to patients with mental health issues, and suggested that lack of exposure to this patient group inhibited their ability to provide them with compassionate care. Barrett and Jackson (2013) recognised the need for adult nursing students to be educated and prepared to support the needs of patients with mental health issues, and that adult nurses will encounter patients

whose physical health is influenced by their mental health. EDs are one environment in which patients whose presentations might relate to mental health issues are cared for mainly by adult registered nurses.

Regular attendees

The participants identified people who attend EDs regularly as a barrier to providing compassionate care. A range of terms are used to describe this patient group including regular attender, regular, frequent attender, frequent flier and repeater (Baston 2005). In this study, the participants used 'regular attender' or 'frequent attender', although one student quoted nurses using 'repeat offender' to describe these patients. The participants made links between patients who attended regularly and those with mental health, drug or alcohol issues, and regarded these as causative factors: 'They (the staff) call them "the regulars". If it was someone like that who had come in, I don't feel the staff would... they weren't as compassionate to them as they would have been to another patient' (Danielle).

Regular attendees represent approximately 5% of all patients who attend EDs yet account for 21% to 28% of all visits [what do you mean by visits?] and associated costs (Soril et al 2016). Bergman (2012) identified feelings of frustration among nurses regarding regular attendees, while Fry (2012) and Hillman (2014) suggested nurses made judgements about the 'worthiness' of patients who attended the EDs. Those who breached nurses' ideas of worthiness engendered feelings of resentment and could experience negative consequences such as longer waiting times for treatment (McConnell et al 2016). An alternative consequence could be reduced compassionate care as exemplified by Danielle's quote.

Two of the participants identified a different type of regular attendee, as patients with chronic conditions who they had seen before in the ED and who were en route to another care setting. In this instance, familiarity between the student and the patient acted to promote compassionate care: 'Like you see one person coming in and say we've (they've) got urology problems so they are a frequent... and I don't know the right words to say, but they are (a) frequent patient in A&E because that is the way they can only get admitted to the ward' (Leeanne).

Physicality of the department

Participants believed the physicality of the department had a detrimental effect on their ability to provide compassionate care. For example, they discussed the lack of available cubicles and expressed concern that patients were often left in corridors in pain, vomiting or exposed. Issues related to equipment were also considered barriers to compassionate care: 'The setup with the cubicles and things isn't always the greatest. Em, or even silly things like the trolleys don't... the height, it doesn't really go, they don't go down very far. So if you are a wee buddy with stiff hips it is really difficult to get on and off' (Katrina).

This is supported by Person et al (2013) who reported that participants expressed concerns about patients on stretchers in the corridors, limited space and issues with equipment and technology. Meanwhile, Timmins et al (2014) reported that emergency nurses attempted to provide compassionate care, but were prevented from doing so due to a lack of basic equipment such as pillows. Other research of patients' experiences of EDs has criticised the care environment, citing uncomfortable trolleys (Gordon et al 2010), while Walsh and Knott (2010) found that patients ranked the cleanliness of the department, the comfort of trolleys and modern equipment as highly important.

One participants in this study highlighted the lack of cubicles and the competing demands from different specialties for space to assess patients as barriers to compassionate care: 'People on corridors and moving people out to move people in to get assessed and then back out. That's just horrendous. I would hate to be sick there, lying in a corridor where people can walk by and see that, and it's sick the way... writhing about in pain or vomiting and, or having bits exposed because you're moving about that don't need to be and I think that's just, it's not very pleasant' (Ellie). Ellie also discussed the negative effects of this on staff. Hamilton et al (2013) recognised this phenomenon and suggested that staff can feel frustrated and disempowered as a result.

Time and government targets

One of the main findings of the study centres on the effects of time. 14 of the 15 participants discussed this topic, and identified a lack of time as a barrier to compassionate care. This mirrors Curtis et al's (2012) work in which nursing students identified that having time to spend with patients was central to the ability to provide compassionate care. In the present study, participants suggested that ED nurses did not have the time to spend with patients to provide compassionate care as they were required to move quickly from one to the next: 'Lack of time is a definite big barrier to compassion... I think a nurse wants to be able to spend more time with their patients and that then would allow them to deliver compassion' (Robert).

Gallagher et al (2014) found that lack of time was a significant factor in preventing nurses from providing quality nursing care to older adults in EDs. Competing acute care priorities were also identified as factors, and caused frustration for the nurses who felt they could not deliver the care they wanted (Gallagher et al 2014). Enns and Sawatzky (2016) also reported that nurses are concerned about the lack of time available to spend with patients as this results in the provision of minimal levels of care. However, participants in this study recognised the importance of maximising the time that is available, to foster the provision of compassionate care.

As highlighted in part 1 [sub please add reference], the participants suggested that building relationships with patients and their loved ones is central to the compassionate care, however as a consequence of having limited time they perceived these relationships as superficial. Rios-Risquez and Garcia-Izquierdo (2016) suggest that the short-term interactions between ED nurses and patients can result in a lower level of emotional involvement on the part of the nurses. ED nurses have also expressed concerns that patients are at risk of being 'lost in the system' because of the nature of the environment (Enns and Sawatzky 2016). McConnell et al (2016) recognise that the challenges of patient throughput, and the focus in EDs on tasks and interventions, result in fragmented care delivery and staff inability to fully engage with patients. One explanation for these superficial relationships may be the nature of emergency nursing. For example, an American study found that registered nurses in EDs spent 25.6% of their time delivering direct patient care compared to 48.4% performing indirect patient care, and that these percentages were nearly constant regardless of the department workload (Hobgood et al 2005).

Another element the participants identified as a barrier, that links with the notion of time, was the effect of the government policy (Department of Health 2000, Scottish Government 2007) to discharge, admit or transfer patients from EDs within four hours of arrival. The students expressed concern that four hours was sometimes insufficient to assess patients, perform investigations, diagnosis and develop a treatment plan. Mortimore and Cooper (2007) found that emergency nurses were concerned that the four hour target compromised the quality of care and that focusing on meeting the target shifted priority from clinical need, thus limiting communication and treatment contact with patients. Hoyle and Grant (2015) identified similar concerns from nurses, including that the four hour target resulted in less time to care for the sickest patients and that care was sometimes compromised to meet the target (Hoyle and Grant 2015). One of the participants in this study said: 'This four hour time limit. Em, personally I think is a joke, like to come in, to tell your symptoms, to see how quickly you get on the queue of priorities, to then, em, get your blood test results back and if you're getting kept in, staying home, those four hours are not long enough to deliver what you need to do' (Leeanne).

Participants commented on the media portrayal of the four-hour target. One explanation of this is the high degree of interest in the target, brought to the public's attention by the media in the wake of the serious concerns about the care at Mid-Staffordshire NHS Foundation Trust (Hoyle and Grant 2015).

The participants suggested that ED staff were often blamed, or faced criticism from the public and media, for patients waiting longer than the four-hour target when in fact the problems were related to bed management. They had witnessed bed managers in the EDs attempting to improve patient flow. Bed management is complex and stressful, and staff in this role must deal with internal and external factors while juggling competing demands for

resources (Proudlove et al 2007). Proudlove et al (2007) also raised the importance of good working relationships between bed managers and nurses, and the participants in this study regarded bed managers as people who interact actively with nurses in EDs and other clinical areas to improve patients' experience.

Staffing levels

The final barrier identified by the student participants was staffing levels. Almost half of the participants commented on the negative effects of poor staffing levels on delivery of compassionate care, which supports the literature (Francis 2013). National Institute for Health and Care Excellence (NICE) (2014) guidelines on safe nurse staffing levels in adult acute inpatient wards recognises there is no single correct staff to patient ratio that can be applied to all wards, and that it is therefore the responsibility of each area to calculate their own staffing requirements. An audit by Wise et al (2015) concluded that guaranteed minimum staffing numbers are required, but that they must be flexible to respond to patient need. Wise et al (2015) do not recommend a guaranteed minimum staffing level, but suggest the need for further research to explore links between ED staffing levels and patient outcomes.

From the participants' perspectives, issues associated with staffing levels became affected their supernumerary status, and resulted in less time to spend to provide compassionate care to patients. As one participant noted: 'Not enough staff. When you go in for a shift and you are meant to be supernumerary, but you're trying to do the job of maybe a clinical support worker because they're short staffed that day and you've not got the time that you would normally have to spend with your patients, making sure they've got, you know, a glass of water or got an extra blanket or things like that. That was quite tough' (Lucie).

Students often have to negotiate how to be supernumerary in clinical areas (Allan et al 2011), and research suggests that they are willing to sacrifice their learning needs to be seen as part of a clinical team and pass their practice assessment (Elcock et al 2007). Shepherd and Uren (2014) warn there is a risk that students provide unsupervised care when their ability to do has not been assessed if their supernumerary status is unprotected, and suggests that supernumerary status can support mentors as it allows them to focus on student learning rather than supervising an apprentice, and supports the assessment process as students develop.

The participants believed that EDs require dedicated staff to manage patients with mental health issues, which linked to their discussions about the care offered to this client group and their general concerns that they are offered less compassion than those with physical illness or injury. Students reported feeling distressed and concerned that patients with mental health presentations, such as self-harm or suicidal ideation, left the EDs while at risk of further harm. The literature, although limited, supports the presence of mental health nurses in EDs, and having mental health liaison nurses based in an ED can help emergency nurses feel more supported and confident when caring for this patient group (Waghorn 2010).

Conclusion

The student participants identified and discussed six barriers to the provision of compassionate care in EDs, none of which were surprising, and all of which are reflected in the literature. This study adds nursing students' experiences to the research base, including the idea that these barriers are not clear cut, and that at times they found ways to overcome them or witnessed ED staff finding ways to provide compassionate care despite them.

References

- Allan H, Smith P, O'driscoll M (2011) Experiences of supernumerary status and the hidden curriculum in nursing: a new twist in the theory-practice gap? *Journal of Clinical Nursing*. 20, 5/6, 847-855.
- Archer J, Dargan P, Wood D et al (2013) Hospital and prehospital emergency service utilisation as an impact of acute recreational drug and ethanol toxicity. *Journal of Substance Use*. 18, 2, 129-137.

- Barrett P, Jackson A (2013) Swimming without the water: a critical perspective on mental health experience for adult nursing students. *Nurse Education in Practice*. 13, 6, 487-491.
- Baston S (2005) Regular attenders at A&E. *Emergency Nurse*. 13, 5, 20-22.
- Bergman C (2012) Emergency nurses' perceived barriers to demonstrating caring when managing adult patients' pain. *Journal of Emergency Nursing*. 38, 3, 218-225.
- Braun V, Clarke V (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*. 3, 2, 77-101.
- Conlon M, O'Tuathail C (2012) Measuring emergency department nurses' attitudes towards deliberate self-harm using the Self-Harm Antipathy Scale. *International Emergency Nursing*. 20, 1, 3-13.
- Crothers C, Dorrian J (2011) Determinants of nurses' attitudes towards the care of patients with alcohol problems. *ISRN Nursing*. 2011, 1-11.
- Currie C, Davies A, Blunt I et al (2015) Alcohol-Specific Activity in Hospitals in England. Nuffield Trust, London.
- Curtis K, Horton K, Smith P (2012) Student nurse socialisation in compassionate practice: a grounded theory study. *Nurse Education Today*. 32, 7, 790-795.
- Delaforce C, Dolan B (2013) Mental health emergencies. In Dolan, B and Holt L (Eds) *Accident and Emergency: Theory into Practice*. Third edition. Bailliere Tindall Elsevier, Edinburgh, 211-226.
- Department of Health (2000) *The NHS Plan. A Plan for Investment. A Plan for Reform*. The Stationary Office, London.
- Elcock K, Curtis P, Sharples K (2007) Supernumerary status: an unrealised ideal. *Nurse Education in Practice*. 7, 1, 4-10.
- Enns C, Sawatzky J (2016) Emergency nurses' perspectives: factors affecting caring. *Journal of Emergency Nursing*. 42, 3, 240-245.
- Ferns T, Cork A (2008a) Managing alcohol related aggression in the emergency department (part 1). *International Emergency Nursing*. 16, 1, 43-47.
- Ferns T, Cork A (2008b) Managing alcohol related aggression in the emergency department (part 2). *International Emergency Nursing*. 16, 2, 88-93.
- Francis R (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. The Stationary Office, London.
- Fry M (2012) An ethnography: understanding emergency nurses practice belief systems. *International Emergency Nursing*. 20, 3, 120-125.
- Gallagher R, Fry M, Chenoweth L et al (2014) Emergency department nurses' perceptions and experiences of providing care for older people. *Nursing and Health Sciences*. 16, 4, 449-453.
- Gilchrist H, Jones S, Barrie L (2011) Experiences of emergency department staff: Alcohol-related and other violence and aggression. *Australasian Emergency Nursing Journal*. 14, 1, 9-16.
- Gordon J, Sheppard L, Anaf S (2010) The patient experience in the emergency department: a systematic synthesis of qualitative research. *International Emergency Nursing*. 18, 2, 80-88.
- Hamilton R, Dolan B, Ardagh M (2013) Creating patient flow. In Dolan B and Holt L (Eds) *Accident and Emergency: Theory into Practice*. Third edition. Bailliere Tindall Elsevier, Edinburgh, 577-586.
- Hillman A (2014) 'Why must I wait?' The performance of legitimacy in a hospital emergency department. *Sociology of Health and Illness*. 36, 4, 485-499.
- Hobgood C, Villani J, Quattlebaum R (2005) Impact of emergency department volume on registered nurse time at the bedside. *Annals of Emergency Medicine*. 46, 6, 481-489.
- Hoyle L, Grant A (2015) Treatment targets in emergency departments: nurses' views of how they affect clinical practice. *Journal of Clinical Nursing*. 24, 15/16, 2211-2218.
- Indig D, Copeland J, Conigrave K et al (2009) Attitudes and beliefs of emergency department staff regarding alcohol related presentations. *International Emergency Nursing*. 17, 1, 23-30.
- Jones R, Avies-Jones A (2007) An audit of the NICE self-harm guidelines at a local accident and emergency department in North Wales. *Accident and Emergency Nursing*. 15, 4, 217-222.
- McCann T, Clark E, McConnachie S et al (2006) Accident and emergency nurses' attitudes towards patients who self-harm. *Accident and Emergency Nursing*. 14, 1, 4-10.
- McConnell D, McCance T, Melby V (2016) Exploring person-centredness in emergency departments: a literature review. *International Emergency Nursing*. 26, 38-46.
- McLaughlin S, Gorley L, Moseley L (2009) The prevalence of verbal aggression against nurses. *British Journal of Nursing*. 18, 12, 735-739.
- Mortimore A, Cooper S (2007) The '4 hour target': emergency nurses' views. *Emergency Medicine Journal*. 24, 6, 402-404.

- National Institute for Health and Clinical Excellence (2014) Safe Staffing for Nursing in Adult Inpatient Wards in Acute Hospitals. National Institute for Health and Clinical Excellence, Manchester.
- Neades B (2013) Aggression. In Dolan B and Holt L (Eds) *Accident and Emergency: Theory into Practice*. Third edition. Bailliere Tindall Elsevier, Edinburgh, 183-189.
- Person J, Spiva L, Hart P (2013) The culture of an emergency department: an ethnographic study. *International Emergency Nursing*. 21, 4, 222-227.
- Polling C, Tulloch A, Banerjee S et al (2015) Using routine clinical and administrative data to produce a dataset of attendances at Emergency Departments following self-harm. *BMC Emergency Medicine*. 15, 1, 15-18.
- Powley D (2013) Reducing violence and aggression in the emergency department. *Emergency Nurse*. 21, 4, 26-29.
- Proudlove N, Boaden R, Jorgensen J (2007) Developing bed managers: the why and the how. *Journal of Nursing Management*. 15, 1, 34-42.
- Rios-Risquez M, Garcia-Izquierdo M (2016) Patient satisfaction, stress and burnout in nursing personnel in emergency departments: a cross-sectional study. *International Journal of Nursing Studies*. 59, 60-67.
- Rolfe A, Dalton S, Krishnan M et al (2006) Alcohol, gender, aggression and violence: findings from the Birmingham Untreated Heavy Drinkers Project. *Journal of Substance Use*. 11, 5, 343-358.
- Sandelowski M (2000) Whatever happened to qualitative description? *Research in Nursing and Health*. 23, 4, 334-340.
- Sandelowski M (2010) What's in a name? Qualitative description revisited. *Research in Nursing and Health*. 33, 1, 77-84.
- Scottish Government. (2007) *Better Health, Better Care: Action Plan*. Scottish Government, Edinburgh.
- Shepherd P, Uren C (2014) Protecting students' supernumerary status. *Nursing Times*. 110, 20, 18-20.
- Soril LJ, Leggett L, Lorenzetti D et al (2016) Characteristics of frequent users of the emergency department in the general adult population: a systematic review of international healthcare systems. *Health Policy*. 120, 5, 452-461.
- Stebbins R (2001) *Exploratory Research in the Social Sciences*. Sage Publications, London.
- Tan M, Lopez V, Cleary M (2015) Nursing management of aggression in a Singapore emergency department: a qualitative study. *Nursing and Health Sciences*. 17, 3, 307-312.
- Timmins F, Bennett P, Norton C (2014) Providing compassionate care to patients on Emergency Department trolleys: can we do more? *Nursing in Critical Care*. 19, 3, 114-116.
- Waghorn J (2010) The impact of basing mental health liaison nurses in an emergency department at night. *Journal of Psychiatric and Mental Health Nursing*. 17, 7, 647-650.
- Walsh M, Knott J (2010) Satisfaction with the emergency department environment decreases with length of stay. *Emergency Medicine Journal*. 27, 11, 821-828.
- Warren O, Sena V, Choo E et al (2012) Emergency physicians' and nurses' attitudes towards alcohol-intoxicated patients. *The Journal of Emergency Medicine*. 43, 6, 1167-1174.
- Wise S, Fry M, Duffield C et al (2015) Ratios and nurse staffing: the vexed case of emergency departments. *Australasian Emergency Nursing Journal*. 18, 1, 49-55.